IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 26, 2009

Tom Whittemore
Communicare, Inc #2 Boone
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #2 Boone, provider #13G009

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #2 Boone, which was conducted on June 22, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 8, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 8, 2009. If a request for informal dispute resolution is received after July 8, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

M. Williams

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

CommuniCare, Inc.
40 West Franklin, Unit F
Meridian, Idaho 83642

Phone (208) 888-1155
Fax (208) 888-1156

Date: 7-15-2009 Time: _____ A.M./P.M. Fax #: 364-1888

To: Monica Williams, Surveyor

Subject: CCI #2 POC

From: Tom Whittemore

Comments: Thanks for the extension —

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G009	A. BUILDING _____ B. WING _____	06/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #2 BOONE	1210 W BOONE ST NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactivity Disorder AQ - Assistant Qualified Mental Retardation Professional BMP - Behavior Management Program IPP - Individual Program Plan LPN - Licensed Practical Nurse LW - Lead Worker NOS - Not Otherwise Specified QMRP - Qualified Mental Retardation Professional	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 2 of 4 individuals (Individuals #1 and #4) whose records were reviewed. This resulted in insufficient information being maintained for individuals. Findings include: 1. Individual #1's IPP, dated 4/2/09, documented a 36 year old male diagnosed with profound	W 111	W111 Corrective Actions: Individual #1: A medication reduction plan was redone by the QMRP Supervisor 03/24/09 which has the correct diagnostic information based on a clarification meeting with the psychiatric services provider in December 2008 which is documented on the Behavior Management/Support Plan (BMP). This document apparently was not attached to the official copy of the BMP in the permanent record but is attached for review. The informed consent was obtained prior to this diagnostic clarification (12/08) but did reflect diagnostic information being used	8/22/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tom Williamson — Administrator — 7-15-2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 mental retardation, autism, and mood disorder NOS. Review of Individual #1's records showed the following concerns: a. Individual #1's Psychoactive Medication Reduction Plan, dated 8/27/08, documented he received Effexor (an antidepressant drug) and Catapres Patch (an antihypertensive drug) for the diagnoses of impulse control disorder and intermittent explosive disorder. However, Individual #1's diagnoses did not include impulse control disorder. During an interview on 6/18/09 from 10:45 - 11:50 a.m., the LPN stated she was unaware of impulse control disorder as a diagnosis for Individual #1. b. Individual #1's Behavior Management Plan, revised 1/09, documented Individual #1 received Effexor and Catapres Patch for mood disorder NOS. However, his Psychoactive Medication Authorization and Informed Consents, dated 10/1/08, documented he received the drugs to "...assist him to manage his own behavior, particularly agitation related to his diagnosis of ADHD." However, ADHD was not listed as a current diagnosis for Individual #1. During an interview on 6/22/09 at 3:00 p.m., the QMRP Supervisor stated the diagnoses listed on the Behavior Management Plan (autism, mood disorder NOS, and intermittent explosive disorder) were accurate for Individual #1. c. Individual #1's Hearing Evaluation, dated 4/1/09, documented Individual #1 required a 2	W 111	when it was developed (10/08). The use of Xanax for all medical appointments will be clarified however, we have not been considering a hearing appointment specifically as a medical appointment but rather as an assessment. Informed consents will be reprocessed with correct diagnostic information and the medication reduction plan will be updated related to which appointments (medical verses assessment) for which a pre-medication is medically necessary. Individual #4: The physical therapy assessment for Individual #4 has not occurred. This is an oversight on our part. Upon person #4's admission he presented immense maladaptive behavioral concerns which required immediate attention by our staff and staff from other agencies as we diligently strove to meet his most critical needs his PT evaluation was not scheduled. It now has been scheduled. This is an unusual situation and we have policies in effect requiring initial evaluations be routinely completed prior to the 30 Day Staffing. Identifying Others Potentially Affected: Psychiatric diagnostic information was reviewed for all individual's living at this location 12/08 during a meeting with the Sun Health psychiatric services provider, the QMRP Supervisor, and the RN Supervisor. The issue with Individual #1 appears to be related to the loss of the updated	

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W 111	Continued From page 2 person restraint to accomplish testing. However, when asked on 6/17/09 at 11:30 a.m., the AQ and a direct care staff both stated they were present during the hearing evaluation and Individual #1 was not restrained during the appointment. d. The Psychoactive Medication Authorization and Informed Consent, dated 10/1/08, documented Individual #1 received Xanax (an anti-anxiety drug) to decrease anxiety during "...all medical procedures that deal with his head and face area." However, during an interview on 6/18/09 from 10:45 - 11:50 a.m., the LPN stated Xanax was only used for dental appointments. The facility failed to maintain a record keeping system that contained accurate and complete information for Individual #1. 2. Individual #4's IPP, dated 3/25/09, documented a 17 year old male diagnosed with moderate mental retardation, oppositional defiant disorder, and intermittent explosive disorder. He was admitted to the facility on 2/24/09. Individual #4's Comprehensive Functional Assessment (CFA) was attached to his IPP. His CFA stated he was starting to use communication cards and schedules as recommended by the speech therapist and occupational therapist. However, no such evaluations could be found in his record. Further, a physical therapy evaluation could not be found in his record. When asked, the QMRP stated during an	W 111	medication reduction plan and others have not been affected. System Changes: See "corrective actions". Monitoring: See "corrective actions". In addition the Quality Assurance review system will be scheduled on a semi-annual rather than annual basis and listed on the annual calendar to insure periodic reviews occur.	

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W 111	Continued From page 3 interview on 6/18/09 from 11:15 - 11:25 a.m., the above noted evaluations were conducted within the first thirty days of admission, but no formal reports had been received. The facility failed to ensure Individual #4's record contained evaluations that reflected his current status.	W 111		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the QMRP provided sufficient monitoring for 3 of 4 individuals (Individuals #1 - #3) whose Monthly Summaries were reviewed. That failure resulted in inappropriate revisions to training programs. The findings include: 1. Individual #3's IPP, dated 4/2/09, documented a 33 year old male diagnosed with moderate mental retardation, autism, and generalized anxiety disorder. His Monthly Summaries, dated 7/08 - 4/09, showed the following inappropriate revisions to his training programs. Examples included, but were not limited to, the following: - The Dressing program criteria was set at 88% for 2 consecutive months. In 7/08, the prompt level was changed to no cue. In 11/08, the objective was changed to 88% and the program	W 159	W159 Corrective Actions: We have a system in place which specifies the updating and monitoring process as well as QMRP oversight of this system. Issues noted appear to be a combination of the need for more inservice training for the QMRP, House Manager, and Instructional Leadworker at this location and the need for an increase in periodic monitoring. As of 07/09/09 all data based programs developed from the 04/09 annual staffing have been reviewed either by the QMRP Supervisor or Quality Assurance QMRP to insure a match with goal statements. One of these management level employees will participate in the monthly review process and generation of monthly summaries for at least the next three months or until satisfied that management level understand and can properly implement established updating processes. Identifying Others Potentially Affected: All individuals at this home have been	7/13/2009

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W 159	Continued From page 4 started over. When asked, the LW stated on 6/22/09 at 12:45 p.m., he forgot to add the percentage to the objective in 7/08. However, Individual #3's Annual Summary Overview showed he met and/or exceeded 88% from 5/08 - 4/09. In sum, the program was started over at step one even though criteria had been met since 5/08. - The Wash Hands program criteria was set at 88% for 2 consecutive months. In 9/08, Individual #3 met the first month of the objective on Step 4. In 10/08, the objective was changed to 88% and the program started over. When asked, the LW stated on 6/22/09 at 12:45 p.m., he forgot to add the percentage to the objective in 7/08. However, Individual #3's Annual Summary Overview showed he exceeded 88% from 5/08 - 4/09. In sum, the program was started over at step one even though criteria had been met since 5/08. - The Toileting program criteria was set at 88% for 2 consecutive months. However, in 11/08 and 2/09 the program was revised to the next step prior to Individual #3 meeting criteria at the current step. When asked, the LW stated on 6/22/09 at 12:45 p.m., the program should not have been revised in 11/08 and 2/09. - The Money program criteria was set at 88% for 2 consecutive months. In 8/08, Individual #3 was at 0%. However, in 9/08 the program was revised to the next step prior to Individual #3 meeting criteria at the current step. When asked, the LW stated on 6/22/09 at 12:45 p.m., the program should not have been revised in 9/08. 2. Individual #1's IPP, dated 4/2/09, documented a 36 year old male diagnosed with profound	W 159	identified as potentially affected. System Changes: There will be no changes in the current system; the changes will be in training and monitoring this system. Monitoring: See "corrective actions".	

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W 159	Continued From page 5 mental retardation, autism, and mood disorder NOS. His Monthly Summaries, dated 7/08 - 4/09, showed the following inappropriate revisions to his training programs. Examples included, but were not limited to, the following: - The Dining program criteria was set at 88% for 2 consecutive months. Data for 10/08 showed 63% and data for 11/08 showed 75%. However, the program was revised from Step 2 to Step 3 effective 12/08. - The Oral Care program criteria was set at 88% for 2 consecutive months. Data for 8/08 showed 75% and data for 9/08 showed 100%. However, the program was revised from Step 2 to Step 3 effective 10/08. - The Shaving program criteria was set at 88% for 2 consecutive months. Data for 12/08 showed 75% and data for 1/09 showed 100%. However, the program was revised from Step 2 to Step 3 effective 2/09. During an interview on 6/22/09 from 12:40 - 1:20 p.m., the LW stated the programs listed above should not have been revised. 3. Individual #2's IPP, dated 4/2/09, documented a 40 year old female diagnosed with severe mental retardation and seizure disorder. Her Monthly Summaries, dated 7/08 - 4/09, showed the following inappropriate revisions to her training programs. Examples included, but were not limited to, the following:	W 159		

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W 159	Continued From page 6 - The Dressing program criteria was set at 75% for 2 consecutive months. Data for 10/08 showed 0%, 11/08 data showed 63%, and data for 12/08 showed 0%. However, the program was revised from Step 3 to Step 4 effective 1/09. - The Wash Hand program criteria was set at 88% for 2 consecutive months. Data for 1/09 showed 62% and data for 2/09 showed 94%. However, the program was revised from Step 1 to Step 2 effective 3/09. During an interview on 6/22/09 from 12:40 - 1:20 p.m., the LW stated the programs listed above should not have been revised. The facility failed to ensure the QMRP ensured Individual #1 - #3s' training programs were monitored and appropriately revised.	W 159		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure data was collected on priority objectives for 3 of 4 individuals (Individual #1 - #3) whose Monthly Summaries were reviewed. Failure to document data consistently had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #1's IPP, dated 4/2/09, documented	W 252	W252 Corrective Actions: Management staff are expected to check for adequate documentation by the 15th of the month. Effective immediately, if there is not enough data collection, the QMRP, House Manager, and/or ILW will collect data themselves through the end of the month until sufficient data probes are documented. In addition, the QMRP Supervisor will meet with this management team to determine what other actions will be implemented to insure that a sufficient number of data certified staff are available to complete this activity. Identifying Others Potentially Affected: All individuals at this home have been	7/13/2009

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W 252	Continued From page 7 a 36 year old male diagnosed with profound mental retardation, autism, and mood disorder NOS. Review of Individual #1's Monthly Summaries showed the following programs with no data being collected: - The Bathing program was missing data for the months 6/08 - 9/08. - The Money program was missing data for the months 2/09 - 4/09. When asked during an interview on 6/18/09 from 10:45 - 11:50 a.m., the QMRP stated she did not know what happened to the data for bathing. When asked, the LW stated on 6/22/09 at 12:45 p.m., there was no data certified staff to collect data on the money program. 2. Individual #2's IPP, dated 4/2/09, documented a 40 year old female diagnosed with severe mental retardation and a seizure disorder. Review of Individual #2's Monthly Summaries showed the following programs with no data being collected: - The Shower program was missing data for the months 7/08 - 9/08, and documented there was not enough data for the months of 3/09 and 4/09. - The Bathing program was missing data for the months 6/08 - 9/08. - The Communication, Task Clean Up, Sensory Touch, Music Leisure, and 3 Step Instruction	W 252	identified as potentially affected. System Changes: See "corrective actions". Monitoring: Starting 07/09 either the QMRP Supervisor or a Quality Assurance QMRP will participate in the monthly summary update process for the next three months or until satisfied that issues of adequate documentation are solved.	

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W 252	Continued From page 8 programs all documented insufficient data probes for the months of 2/09 and 3/09. When asked during an interview on 6/22/09 from 12:40 - 1:20 p.m., the LW stated there was no data certified staff to collect data. 3. Individual #3's IPP, dated 4/2/09, documented a 33 year old male diagnosed with moderate mental retardation, autism, and generalized anxiety disorder. Individual #3's Monthly Summaries, dated 2/09 and 3/09, showed no data was collected on the following programs: Homemaking, Money, Janitorial, Voc/Office, and Perceptual Motor. When asked, the LW stated on 6/22/09 at 12:45 p.m., there was no data certified staff to collect data during the above noted months. The facility failed to ensure data was collected as specified in Individuals #1 - #3s' IPPs.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 4 individuals (Individual #4)	W 262	W262 Corrective Actions: We were viewing the addition of one-to-one staff as supportive rather than restrictive. Now that this has been clarified for us this individual's BMP has been updated to clarify this as a restrictive element and the consent for the BMP will be reprocessed for HRC review by the QMRP. Identifying Others Potentially Affected: No other individual's have this type of support/restriction at this location.	8/22/2009

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W 262	Continued From page 9 whose behavioral interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals on restrictive interventions. The findings include: 1. Individual #4's IPP, dated 3/25/09, documented a 17 year old male diagnosed with moderate mental retardation, oppositional defiant disorder, and intermittent explosive disorder. He was admitted to the facility on 2/24/09. During observations conducted at the facility on 6/15/09 and 6/16/09 for a cumulative 4 hours 48 minutes, Individual #4 was noted to have one-to-one staff. When asked, the AQ stated on 6/16/09 at 1:30 p.m., Individual #4 was placed on one-to-one supervision from 9:00 a.m. to 9:00 p.m., approximately 6 weeks after admission, due to his aggressive behavior. Individual #4's BMP, revised 6/09, stated "One-to-one staffing was assigned..." There was no other mention of increased supervision in the BMP. Individual #4's record did not contain approval from the facility's HRC for the BMP or increased supervision. When asked, the QMRP stated during an interview on 6/18/09 from 11:15 - 11:25 a.m., approval was obtained earlier that morning (on 6/18/09). The facility failed to ensure HRC approval was obtained for increased supervision of Individual #4 prior to the intervention being used.	W 262	System Changes: We will clarify for all QMRP's that one-to-one staffing is a restrictive element which requires informed consent. Monitoring: Consent will be reviewed during the now scheduled semi-annual Quality Assurance review process which will be designated on annual CCI calendars.	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs	W 263	W263 Corrective Actions: We were viewing the addition of one-to-one staff as	7/13/2009

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	13G009	A. BUILDING _____ B. WING _____	06/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 263	Continued From page 10 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 4 individuals (Individual #4) whose behavioral interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of a restrictive intervention. The findings include: 1. Individual #4's IPP, dated 3/25/09, documented a 17 year old male diagnosed with moderate mental retardation, oppositional defiant disorder, and intermittent explosive disorder. He was admitted to the facility on 2/24/09. During observations conducted at the facility on 6/15/09 and 6/16/09 for a cumulative 4 hours 48 minutes, Individual #4 was noted to have one-to-one staff. When asked, the AQ stated on 6/16/09 at 1:30 p.m., Individual #4 was placed on one-to-one supervision from 9:00 a.m. to 9:00 p.m., approximately 6 weeks after admission, due to his aggressive behavior. Individual #4's BMP, revised 6/09, stated "One-to-one staffing was assigned..." There was no other mention of increased supervision in the BMP. Individual #4's record did not contain consent from his legal guardian for the BMP or increased supervision. When asked, the QMRP stated during an	W 263	supportive rather than restrictive. Now that this has been clarified for us this individual's BMP has been updated to clarify this as a restrictive element and the consent for the BMP will be reprocessed for legal guardian review by the QMRP. Identifying Others Potentially Affected: No other individual's have this type of support/restriction at this location. System Changes: We will clarify for all QMRP's that one-to-one staffing is a restrictive element which requires informed consent. Monitoring: Consent will be reviewed during the now scheduled semi-annual Quality Assurance review process which will be designated on annual CCI calendars.	

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W 263	Continued From page 11 interview on 6/18/09 from 11:15 - 11:25 a.m., consent was obtained earlier that morning (on 6/18/09). The facility failed to ensure guardian consent was obtained for increased supervision of Individual #4 prior to the intervention being used.	W 263		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into the program plan for 1 of 4 individuals (Individual #4) whose behavior interventions were reviewed. This resulted in an intervention being used that was not included in an individual's program plan. The findings include: 1. Individual #4's IPP, dated 3/25/09, documented a 17 year old male diagnosed with moderate mental retardation, oppositional defiant disorder, and intermittent explosive disorder. He was admitted to the facility on 2/24/09. During observations conducted at the facility on 6/15/09 and 6/16/09 for a cumulative 4 hours 48 minutes, Individual #4 was noted to have one-to-one staff. When asked, the AQ stated on	W 289	W289 Corrective Actions: We were viewing the addition of one-to-one staff as supportive rather than restrictive. Now that this has been clarified for us this individual's BMP has been updated to clarify this as a restrictive element. Identifying Others Potentially Affected: No other individual's have this type of support/restriction at this location. System Changes: We will clarify for all QMRP's that one-to-one staffing is a restrictive element which must be identified as such in individuals BMPs. Monitoring: The QMRP Supervisor will insure that one-to-one supervision is included as a restrictive element in all BMPs and QMRPs will review all BMPs developed by the QMRP Supervisor.	7/13/2009

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W 289	Continued From page 12 6/16/09 at 1:30 p.m., Individual #4 was placed on one-to-one supervision from 9:00 a.m. to 9:00 p.m., approximately 6 weeks after admission, due to his aggressive behavior. Individual #4's BMP, revised 6/09, stated that "One-to-one staffing was assigned ..." There was no other mention of increased supervision in the BMP. When asked, the QMRP stated during an interview on 6/18/09 from 11:15 - 11:25 a.m., one-to-one supervision was not incorporated into Individual #4's BMP as it was seen as a safety issue. The facility failed to ensure the use of increased supervision was incorporated into Individual #4's BMP.	W 289		
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to take actions to correct problems that were identified during quarterly evacuation drills for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: 1. The facility's Evacuation Drill Reports from 7/08 to 6/09 were reviewed. The reports documented the following: - The night shift evacuation, dated 7/24/08, documented an evacuation time of 20 minutes.	W 449	W449 Corrective Actions: We have a system for investigation of problematic fire drills (see attached). The House Manager and QMRP will be re-inserviced as to this process. Identifying Others Potentially Affected: All individuals at this location are potentially affected. System Changes: There will be no changes in the current system; the changes will be in re-inservicing and monitoring this system. Monitoring: The Administrator will establish a "problem" evacuation drill time for each shift and any drill which	8/22/2009

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W 449	Continued From page 13 - The night shift evacuation, dated 10/13/08, documented an evacuation time of 7 minutes. - The day shift evacuation, dated 12/22/08, documented an evacuation time of 6 minutes. - The night shift evacuation, dated 4/15/09, documented an evacuation time of 8 minutes. - The night shift evacuation, dated 6/3/09, documented an evacuation time of 6 minutes. However, there was no documentation of corrective action. When asked during an interview on 6/18/09 from 10:45 - 11:50 a.m., the QMRP stated there was no corrective action taken. The facility failed to ensure corrective action was taken for evacuations with extended periods of time.	W 449	exceeds this time will be followed up with an analysis which will be submitted to him.	

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 Please refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 Please refer to W263	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	MM197 Please refer to W289	
MM336	16.03.11.110.04(b) Emergency Plans Emergency plans must be thoroughly tested and used as necessary to assure rapid and efficient function. This Rule is not met as evidenced by: Refer to W449.	MM336	MM336 Please refer to W449	
MM537	16.03.11.210.01(b) Documentary Evidence Documentary evidence of the resident's progress and of his response to his habilitation program; This Rule is not met as evidenced by:	MM537	MM537 Please refer to W111	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-15-2009

STATE FORM 6899 220D11 If continuation sheet 1 of 2

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MM537	Continued From page 1 Refer to W111.	MM537		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	MM725 Please refer to W159	
MM860	16.03.11.270.08(f)(ii) Recording Progress Recording each resident's progress; and This Rule is not met as evidenced by: Refer to W252.	MM860	MM860 Please refer to W252	